

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?  
 \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Cecil  
 City or town... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Rev. Dr. James Warren Albinson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Virginia C. Albinson6. (c) If alive, give age 37 years

7. Birth date of

deceased (mo., day, yr.)

November 10, 1896

8. AGE:

Years

Months

Days

If less than one day

5215

hrs.

min.

9. Birthplace

Bloomfield, New Jersey

(Town, county, and state)

10. Usual occupation

Clergyman

11. Industry or business

Episcopal

FATHER

12. Name

Thomas Albinson

13. Birthplace

England

MOTHER

14. Maiden name

Margaret Murphy

15. Birthplace

Pennsylvania

16. Informant

Virginia C. Albinson

Address

Elkton, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 27, 1948  
(month) (day) (year)

Cemetery or crematory

St. Mark's Cemetery

Location

Aikin, Maryland

18. Funeral director

Address

Lee A. Patterson & Son  
Ferryville, Md.

19.

(Date rec'd by registrar)

Nov 27 1948J. R. Brazier

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 November 19 48 at 9:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 November 19 48 to 25 November 19 48and that I last saw him alive on 25 November 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

12 hrs

Due to

Hypertension8 yrs

Due to

Arteriosclerosis

Other conditions

Cardio Renal disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

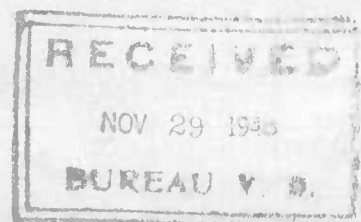
George J. Kuen, Jr.  
Elkton, Md.

M. D. or other

Address

Date signed

25 Nov 48



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11333

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil

City or town... Eekton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 68 days

## 3. (a) FULL NAME

Harry Herbert Austin

## 3. (b) Social Security Number

(Austin)

## 4. Sex

Male

## 5. Color of race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ethel M. Austin

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.) Sept 29-1890

## 8. AGE:

Years

Months

Days

If less than one day

58

1

16

hrs.

min.

## 9. Birthplace

New Castle Co. Delaware

(Town, county, and state)

## 10. Usual occupation

Electrician

## 11. Industry or business

Electrician

## MOTHER

## FATHER

## 12. Name

Harry Austin

## 13. Birthplace

New Castle Co Del.

## 14. Maiden name

Mary Jane Isaac

## 15. Birthplace

Sussex Co. Del.

## 16. Informant

Hester Reese

## Address

Union Hosp. Eekton Md

## 17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

11/19/48

(month) (day) (year)

## Cemetary or crematory

Bethel Cemetery

## Location

near Chesapeake City Md

## 18. Funeral director

E. J. Daniels

## Address

Middletown Del.

## 19. (Date rec'd by registrar)

Nov 17 1948

J. F. Frazier

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Earlsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 1400 (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948 at 2 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Nov 15 1948

and that I last saw him alive on Nov. 15 1948

Immediate cause of death

Right hemiplegia

Due to

Hypertension CVD disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Daniels M.D.

Address Chesapeake City Md Date signed 11/15/48

## DURATION

Sept 7

1948

2 years

RECEIVED

NOV 20 1948

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11334

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County Accil  
 City or town Chesapeake City R D  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Accil  
 City or town Chesapeake City R D  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lillian Broadwater Bailey

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Charles H Bailey

7. Birth date of deceased (mo., day, yr.) mch 15 1905 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 43 Months 8 Days 15 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Town Point Accil Md  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name Within Broadwaters  
 13. Birthplace Phila Pa

14. Maiden name Alice Smith  
 15. Birthplace Phila Pa

16. Informant Charles H Bailey  
 Address Chesapeake City Md

17. Burial Date thereof Dec 2 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Johnstown Methodist Church  
 Location Cecilton Md R D

18. Funeral director J & W Pippin  
 Address Elkton Md

19. Dec 1 at 19 48 Jessie Baffin & Baffin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 at 4A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 10 1940 to Nov 13 1948  
 and that I last saw him alive on Nov 30 1948

Immediate cause of death

Anaemia of lungsDue to Solidification of lungsDue to Cancer in lungs

Other conditions Tuberculous infection  
or Circulatory system  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. J. Doran MD  
 M. D. or other \_\_\_\_\_

Address Chesapeake City Md Date signed 12/1/48

## DURATION

3 hours6 years

RECEIVED

DEC 3 1948

BUREAU V. S.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 11335  
 Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Conowingo Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 hours  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Cecil  
 City or town..... Rising Sun Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Ernest McGuffin Brammer

## 3. (b) Social Security Number

229-12-1817

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Mary Brammer

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1893 6.(c) If alive, give age..... 49 years

8. AGE: Years..... 55 Months..... 29 Days..... hrs. .... min.

9. Birthplace..... Simonstown West Va.  
 (Town, county, and state)

10. Usual occupation..... Salesman

## 11. Industry or business

12. Name..... Benjamin H. Brammer  
 13. Birthplace..... Va.

14. Maiden name..... Nancy Eperly  
 15. Birthplace..... Va.

16. Informant..... Mary Brammer  
 Address..... Rising Sun Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof..... Nov 14, 1948  
 (month) (day) (year)

Cemetery or crematory..... West Nottingham  
 Location..... Colona Md.

18. Funeral director..... J. E. Tyson  
 Address..... Rising Sun Md.

19. (Date rec'd by registrar)..... Nov 13, 1948 Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 11, 1948, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....  
 Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:  
 Accident, suicide, or homicide..... Date of .....

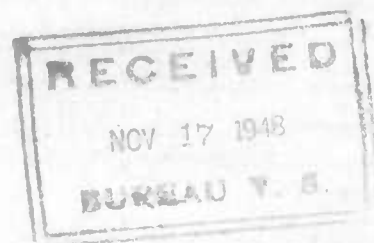
Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....  
 Address.....

Medical Examiner.....  
 for Cecil County  
 M. D. or other.....

Date signed..... 11/12-48





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Rising Sun Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 69 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Cecil  
 City or town Rising Sun Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Howard N. Brickley

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Mary Brickley

7. Birth date of deceased (mo., day, yr.) April 11, 1879 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 69 Month 7 Day 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rising Sun md.  
 (Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

MOTHER FATHER 12. Name William A. Brickley  
 13. Birthplace Rising Sun md.  
 14. Maiden name Rachel Marshall  
 15. Birthplace Rising Sun md.

16. Informant Mrs. Rufus Jackson  
 Address Rising Sun md. R. H. D.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 19, 1948  
 (month) (day) (year)

Cemetery or crematory Ebenezer  
 Location Outside Rising Sun

18. Funeral director J. E. Dyson  
 Address Rising Sun md.

19. Nov. 17 19 48 L. W. Wethington  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Strangulation by hanging

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 11-16-48

Where did injury occur Rising Sun Cecil md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Rope Injured at work? \_\_\_\_\_23. SIGNATURE R. L. Jackson Medical ExaminerAddress Rising Sun md. Date signed 11-17-48

for Cecil County

M. D. or other



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

### 1. PLACE OF DEATH:

County Cecil  
City or town Perry Point  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 mos. 2 days  
Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
How long in hospital or institution? Same

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
City or town Havre de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 608 Pearl Street  
(If rural, give LOCATION)  
2. (a) If veteran, name was VV-I ✓

### 3. (a) FULL NAME

BULETTE, Hugh E.

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Florence Bulette

7. Birth date of deceased (mo., day, yr.) January 8, 1896

8. AGE: Years 52, Months 10, Days 1 If less than one day hrs. min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

12. Name James O. Bulette - deceased

13. Birthplace Harford County, Md.

14. Maiden name Clara Founda

15. Birthplace Cecil County, Md.

16. Informant Wife, Mrs. Florence Bulette

Address 608 Pearl St., Havre de Grace, Md.

17. Burial Date thereof Nov. 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Slate Hill Cemetery

Location Harford County, Maryland

18. Funeral director R. Madison Mitchell

Address Havre de Grace, Md.

19. Nov 10 19 48 James S. Daugherty  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1948, to Nov. 9, 1948

and that I last saw him alive on November 9, 1948

Immediate cause of death Pneumonia, lobar, right lower lobe DURATION 48 hrs.

Due to Abscess, right temporal lobe

Due to Sarcoma, maxillary process, sclerosing type

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Trollinger M. D. or other

A. E. TROLLINGER, M. D., Chief, Professional Svcs.

Address VAH, Perry Point, Md. Date signed 11-10-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11338

Reg. Dist. No. 95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Rising Sun md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Pearl Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Clara O Coale

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Samuel Coale

7. Birth date of deceased (mo., day, yr.) 6-27-1869 6.(c) If alive, give age Deceased years

8. AGE: Years 79 Months 4 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Porters Bridge, Cecil Co, md.  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Samuel A Hindman13. Birthplace Rollinsville, md.14. Maiden name Martha Kennard15. Birthplace Colora, md.16. Informant Harriette LittleAddress Rising Sun, md.17. Burial, cremation, or removal. Which? Burial Date thereof 11-9-48  
(month) (day) (year)Cemetery or crematory West Nottingham AmeloyLocation Colora, md.18. Funeral director Ralph M ReedAddress Rising Sun md19. Date rec'd by registrar Nov 8 1948 Registrar L M Worthington

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1948, at 10:15 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Nov 5 1948and that I last saw him alive on Nov. 4 1948Immediate cause of death Carcinoma of Liver

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. D. or otherAddress Rising Sun md Date signed 11/6-48

MARGIN RESERVED FOR BINDING

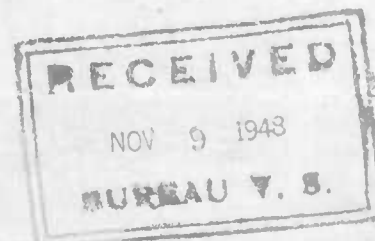
VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permit issued 11-8-1948

1869-6-27

10-35  
1948-XX-  
29-4-8





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11339

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours  
 Hospital, institution, or street address where death occurred:  
Union Hosp. Easton Md.  
 How long in hospital or institution? 3 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Cecil  
 City or town North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joan Marie Cornell.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 24 1948 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.Birthplace North East Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Joseph M. Cornell13. Birthplace Union Sun Md.14. Maiden name Susan Strizack15. Birthplace St Clair, Panama16. Informant Joseph M. CornellAddress North East Md.17. Burial Burial Date thereof 11-8-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brookview CemeteryLocation Union Sun Md.18. Funeral director Joseph B. GrantAddress North East Md.19. Nov 8 19 48 JR Frazer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 19 48 at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Convulsions

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Phl. Rodgerson Medical ExaminerAddress Union Sun Md. for Cecil CountyDate signed 11-5-48



RECEIVED

NOV 10 1948

BUREAU V. S.

RECEIVED

NOV 10 1948

BUREAU V. S.



RECEIVED

NOV 29 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11341

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years.....

Months.....

Days.....

If less than one day.....

hrs.....

min.....

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal, which?).....

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

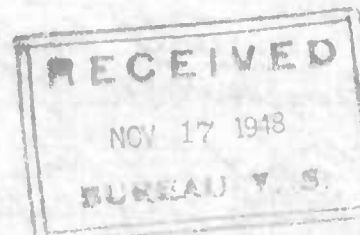
M. D. or other

Address.....

Date signed.....

BUREAU OF GOVERNMENT PRINTING OFFICES

STANDARD FORM NO. 1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11342

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County CECIL COUNTYCity or town ELKTON, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 DAYS

Hospital, institution, or street address where death occurred:

UNION HOSPITALHow long in hospital or institution? 11 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CECILCity or town R.D. 5 Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

WILLIAM DEMPSEY

## 3. (b) Social Security Number

4. Sex MALE5. Color or race WHITE6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife BERTHA6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) JULY 31st 18738. AGE: Years 75 Months 3 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace CECIL COUNTY, MARYLAND  
(Town, county, and state)10. Usual occupation MILL WORKER

11. Industry or business

12. Name JOHN DEMPSEY13. Birthplace MARYLAND14. Maiden name SARA GRAY15. Birthplace MARYLAND16. Informant Mrs. Bertha DempseyAddress Elkton R.D. 517. Burial Date thereof Nov 29, 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Grace Lavin Memorial ParkLocation Wilmington, Del.18. Funeral director R. J. JonesAddress Newark, Del.19. Nov 29, 48 19 48 J. R. Strayer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 48 at 8:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. 48 to Nov 26, 48 and that I last saw him alive on Nov 25, 48Immediate cause of death Carcinoma of Prostate with metastasis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cardio vascular renal disease

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Herbert B. M.D. M. D. or otherAddress Elkton Md Date signed 11/26/48



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BUREAU V. S.



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11343

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h... alive on

Immediate cause of death

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

for Cecil County

M. D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

11344

932

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 months 16 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Same

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_  
 City or town Richmond  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 429 Fulton Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war VV-1 ✓

## 3. (a) FULL NAME

DRAKE, Frank L.

## 3. (b) Social Security Number

215-16-5060

4. Sex male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) Dec. 4, 1896  
 8. AGE: Years 51 Months 11 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Canner  
 11. Industry or business \_\_\_\_\_  
 12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Hospital records  
 Address VA Hospital, Perry Point, Md.  
 17. Burial Date thereof Nov. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Maryland  
 18. Funeral director Pennington & Son  
 Address Havre de Grace, Md.  
 19. Nov 16 19 48 J. E. Troller  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 19 48 at 7:50 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 24, 19 48, to Nov. 10, 19 48  
 and that I last saw him alive on November 10, 19 48

Immediate cause of death Arteriosclerotic heart disease DURATION Unknown

Due to Arteriosclerosis, coronary and cerebral embolus

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. E. Troller  
J. E. TROLLER, M.D., Chief, Professional Svcs.  
 Address VAH, Perry Point, Md. Date signed 11-16-48

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NOV 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County **Cecil**  
 City or town **Perry Point**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **11 mos. 17 days**  
 Hospital, institution, or street address where death occurred:  
**VA Hospital, Perry Point, Md.**  
 How long in hospital or institution? **Same as above**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Baltimore**  
 City or town **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **18 E. 22nd Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war **WW-II** ✓

## 3. (a) FULL NAME

**DUNPHY, Lester J.**

## 3. (b) Social Security Number

**212-12-9702**

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **Married**

6.(b) Name of husband or wife **Marie Dunphy**  
 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) **Sept. 20, 1920**

8. AGE: Years Months Days If less than one day  
**28 1 29** .....hrs. ....min.

9. Birthplace **Baltimore, Md.**  
 (Town, county, and state)

10. Usual occupation **Laborer**

11. Industry or business

FATHER 12. Name **Unknown Lester Gregory Dunphy**  
 13. Birthplace **Unknown Baltimore Md.**

MOTHER 14. Maiden name **Unknown ELIA HAGEN**  
 15. Birthplace **Unknown Baltimore Md.**

16. Informant **Hospital Records**  
 Address **VA Hospital, Perry Point, Md.**

17. **Removal** Date thereof **Nov. 20, 1948**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Baltimore National Cemetery**

Location **Baltimore, Maryland**

18. Funeral director **PENNINGTON & SON**  
 Address **Navre de Grace, Maryland**

19. **Nov. 20** 19 **48** **James E. Dunphy**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **November 19,** 19 **48**, at **12:29 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**December 2,** 19 **47**, to **Nov. 19,** 19 **48**  
 and that I last saw him alive on **November 19,** 19 **48**

Immediate cause of death **Sarcoma, osteogenic, right humerus with metastases, to clavicle, xxx scapula, lungs and plura**  
 DURATION **Approx. 20 months**

Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results **Same as above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE **A.E. TROLLINGER** M. D. or other  
**A.E. TROLLINGER, M.D., Chief, Professional Svcs.**  
 Address **VAH, Perry Point, Md.** Date signed **11-19-48**

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 24 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH 11346

## 1. PLACE OF DEATH

County CecilVillage or City WarwickNo. 159Registration Dist. No. 90St. War

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

2. FULL NAME Baby Ellingsworth, Judith Anne If U. S. Veteran, specify WAR(a) Residence: No. Warwick Md.

St. \_\_\_\_\_ Ward. \_\_\_\_\_

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)  
single5e. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6. DATE OF BIRTH (month, day, end year) Nov. 11th. 1948

7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.  
1

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month end  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town) Warwick Md.  
(State or country)

FATHER

13. NAME Kirby Ellingsworth14. BIRTHPLACE (city or town) Delaware  
(State or country)

MOTHER

15. MAIDEN NAME June Manlove16. BIRTHPLACE (city or town) Md.  
(State or country)17. INFORMANT Kirby Ellingsworth  
(Address) Warwick

18. BURIAL, CREMATION, OR REMOVAL

Place Towson Cemetery Date 11/12/48

19. UNDERTAKER

(Address) Towson20. FILED 11/12/48 Mr. Harvey Delaney

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Nov.  
(Month)11th.  
(Day)1948  
(Year)22. I HEREBY CERTIFY, That I attended deceased from  
11/11/48, 19\_\_\_\_, to 11/11/48, 19\_\_\_\_I last saw her alive on 11/11/48, 19\_\_\_\_; death is said  
to have occurred on the date stated above, at 9 P.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:

Date of onset

Premature birth

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)  
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify

(Signed) Charles H. Keith(Address) Towson, Md.

M. D.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

**Example II**

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

11347

93d

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Elkton Union Hospital  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 69 years  
 Hospital, institution, or street address where death occurred:  
 Union Hosp.  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Cecil  
 City or town... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... East Main St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James F. Evans

## 3. (b) Social Security Number

4. Sex... Male  
 5. Color of race... white  
 6. (a) Single, married, widowed, or divorced... married  
 6.(b) Name of husband or wife... Margaret Evans  
 X  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.)... Jan 19 1973  
 8. AGE: Years 75 Months 10 Days hrs. min.

9. Birthplace... Elkton and Md  
 (Town, county, and state)  
 10. Usual occupation... Lawyer  
 11. Industry or business

MOTHER FATHER  
 12. Name... William Steel Evans  
 13. Birthplace... Rising Sun Md  
 14. Maiden name... Jennie Frazer  
 15. Birthplace... Elkton Md

16. Informant... Stanley Evans  
 Address... Elkton Md

17. Burial Date thereof... Nov 21 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Elkton cemetery  
 Location... Elkton Md  
 H W Pippin

18. Funeral director...  
 Address... Elkton Md

19. Nov 20 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 19<sup>th</sup> 1948 at 3:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12 - 1948 to Nov. 19 1948  
 and that I last saw him alive on Nov. 19<sup>th</sup> 1948

Immediate cause of death... Cerebral embolism  
 Due to... Hypertension & myocardial infarction  
 Due to...  
 Other conditions...  
 (Include pregnancy within 8 months of death)

Major findings of operations...  
 Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE...  
 Address...  
 Date signed... 11/20/48

MARGIN RESERVED FOR BINDING

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VS A15

9-43-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County Hart Cecil  
 City or town Cecil  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all life  
 Hospital, institution, or street address where death occurred:  
Cecil  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town Cecil  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Cecil  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

T. A. Roberts Ferguson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Emma B. Ferguson  
 6.(c) If alive, give age 81 years  
 7. Birth date of deceased (mo., day, yr.) March 22 1957  
 8. AGE: Years 91 Months 8 Days 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace near Cecil, Cecil Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer (retired)  
 11. Industry or business Farming  
 12. Name John Edward Ferguson  
 13. Birthplace Cecil Co. Maryland  
 14. Maiden name Margaret Emma Jones  
 15. Birthplace Cecil Co. Maryland

18. Informant Mrs. Emma B. Ferguson (sister)  
 Address Cecil, Cecil Co. Maryland  
 17. Burial Date thereof Nov. 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cecil  
 Location Cecil, Cecil Co. Maryland  
 18. Funeral director Marvin V. Williams  
 Address Charleston, Maryland

19. Nov 30 19 48 Mr. Harold W. Chappell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948 at 6:30 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 33 to Nov 27 19 48  
 and that I last saw him alive on Nov 26 19 48  
 Immediate cause of death Paralysis of Throat muscles  
 Due to General weakness  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

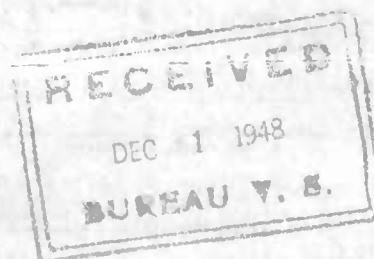
Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. J. Davis MD M. D. or other \_\_\_\_\_  
 Address Chesapeake City, Md. Date signed 11/29/48

11348

115 C



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... North East (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 8 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... North East (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... no

## 3. (a) FULL NAME

Peter David Gysin

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Maysie Alice Gysin  
 7. Birth date of deceased (mo., day, yr.)..... October 10 1900 6. (c) If alive, give age..... 48 years  
 8. AGE: Years..... 48 Months..... 1 Days..... 10 If less than one day..... hrs. .... min.

9. Birthplace..... Switzerland  
 (Town, county, and state)  
 10. Usual occupation..... Salesman  
 11. Industry or business..... Furniture  
 12. Name..... John Gysin  
 13. Birthplace..... Switzerland  
 14. Maiden name..... Bertha David  
 15. Birthplace..... Switzerland

16. Informant..... Mrs. Peter D. Gysin  
 Address..... North East, Md. R.D.

17. Removal..... Removal Date thereof..... Nov. 22 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Oakhill  
 Location..... Battle Creek, Michigan  
 18. Funeral director..... Joseph P. Grant  
 Address..... North East, Maryland

19. Nov 22 19 48 Sarah E. Rothman  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 20, 1948 at..... 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... November 20, 1948 to..... Nov 20, 1948  
 and that I last saw him alive on..... Nov 20, 1948

Immediate cause of death..... Crowning thrombosis of brain  
 DURATION.....

Due to.....

Due to.....

Other conditions..... none

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Dr. Green Conrad W. L.

M. D. or other

Address..... North East Md Date signed..... Nov 21/48

RECEIVED

NOV 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

11350

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs

Hospital, institution, or street address where death occurred:  
Maple St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Maple St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Josephine Lamar Heverin

## 3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Percy B. Heverin

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov. 9, 1870

8. AGE:

Years

Months

Days

If less than one day

78

3

hrs.

min.

9. Birthplace

Perryville, Prince Georges, Md

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

William Lamar

13. Birthplace

Perryville, Md

MOTHER

14. Maiden name

Ms. J. J.

15. Birthplace

16. Informant

Mr. Percy Heverin

Address

Elkton, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 15

(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md

18. Funeral director

H. W. Lippert

Address

Elkton, Md

19. Nov. 15, 1948

(Date rec'd by registrar)

1948

J. R. Brazner

(Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1948, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3, 1948, to November 12, 1948,

and that I last saw her alive on November 12, 1948.

Immediate cause of death

Cerebral hemorrhage

DURATION

2 yrs

Due to

Chs parenchymatous nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James L. Johnson M.D.

M. D. or other

Address

Elkton, Md

Date signed 11/15/48

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

NOV 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

195

1135196  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Cecil County  
 City or town Perry Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Months 11 Days  
 Hospital, institution, or street address where death occurred:  
VAH., Perry Point, Maryland  
 How long in hospital or institution? 2 Months 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_  
 City or town Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 419 Wilkes Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-II

## 3. (a) FULL NAME

JEWELL, Millard E.,3. (b) Social Security Number  
Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Virginia R. Jewell  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 23, 1919  
 8. AGE: Years 29 Months 2 Days 20  
 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, Virginia  
 (Town, county, and state)  
 10. Usual occupation Unknown  
 11. Industry or business Unknown  
 12. Name Charles H. Jewell, Sr.  
 13. Birthplace Viewtown, Virginia  
 14. Maiden name Ophelia Martin  
 15. Birthplace Viewtown, Virginia

16. Informant Hospital Records  
 Address VA Hospital, Perry Point, Md.

17. Removal Date thereof Nov. 15, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Unknown  
 Location Unknown

18. Funeral Pennington & Son  
 Address Havre de Grace, Md.

19. Nov. 15 19 48 James E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948 at 5:47 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death: 1. Fracture of the Parietal  
extending into the frontal. 2. Cerebral  
Hemorrhage. 3. Fracture of 2nd rib,  
left side. 4. Fracture of Rt.  
humerus, multiple. 5. Multiple,  
lacerations of the face and head.  
6. Fracture of the Liver.  
7. Laceration of the mesintery.  
 Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 11-13-48  
 Where did injury occur? VAH, Perry Point, Md. (State)  
 (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?) Hospital Road  
 Means of injury Medical Examined  
 Injured at work? \_\_\_\_\_

23. SIGNATURE R.C. DODSON, M.D. Coroner Cecil County  
Rising Sun, Maryland M. D. or other M.D.  
 Address \_\_\_\_\_ Date signed 11-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11352

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... **CECIL**  
 City or town..... **PERRY POINT, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 mo. 10 das.**  
 Hospital, institution, or street address where death occurred:  
**VA Hospital, Perry Point, Md.**  
 How long in hospital or institution? **Same as above**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Cecil**  
 City or town..... **Elkton**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **139 E. High Street**  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war **WW-I**

## 3. (a) FULL NAME

**ERNEST KEMPA**

## 3. (b) Social Security Number

**215-10-7402**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**  
 6. (b) Name of husband or wife **Esther Kempa**  
 6. (c) If alive, give age **50** years  
 7. Birth date of deceased (mo., day, yr.) **November 27, 1888**  
 8. AGE: Years **59** Months **11** Days **5** If less than one day  
 ..... hrs. .... min.

9. Birthplace **Elkton, Maryland**  
 (Town, county, and state)  
 10. Usual occupation **Clerk**  
 11. Industry or business  
 FATHER 12. Name **Unknown**  
 13. Birthplace  
 MOTHER 14. Maiden name **Unknown**  
 15. Birthplace

16. Informant **Hospital Records**  
 Address **VAH, Perry Point, Md.**  
 17. **Removal** Date thereof **11/2/48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Elkton Cemetery**  
 Location **Elkton, Maryland**  
 18. Funeral director **JOSEPH GRANT**  
 Address **North East, Maryland**  
 19. **Nov 2** 19 **48** **Dr. E. Langley**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **November 2** 19 **48**..... at **6:00A**..M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**September 22** 19 **48**..... to **Nov. 2** 19 **48**.....  
 and that I last saw him alive on **November 2** 19 **48**.....

Immediate cause of death.....  
**Carcinoma of the stomach,**  
**generalized carcinomatosis**

DURATION  
**6 months**

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations **Generalized carcinomatosis,**  
**primary site probably in**  
**recto-sigmoid** Date of op. **9-30-48**

Autopsy results **Confirms above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE **A. E. TROLLINGER, M.D., Chief, Prof. Serv.**  
**VAH, Perry Point, Md.**  
 Address..... Date signed **11/2/48**





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Near Blue Ball, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil  
 City or town Rural District  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Near Blue Ball Md  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret L Kinslow

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored X

6. (b) Name of husband or wife Henry J. Kinslow

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

June 7, 1874  
 8. AGE: 74 Years Months Days If less than one day  
 hrs. min.

9. Birthplace Penna  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Alfred Hammond  
 13. Birthplace Maryland  
 14. Maiden name Rachel Robertson  
 15. Birthplace Maryland

16. Informant Anna Kinslow SmithAddress Elkton Md. RD #4

17. Burial Date thereof 12 3 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Trinity Cemetery, Zion, Md.  
 Location Zion, Md.

18. Funeral director Edw. G. BellAddress 909 S. Plar St. Wil. Del.19. Dec 3 1948  
(Date rec'd by registrar)

H. J. Frazer  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1948 to November 28 1948  
 and that I last saw her alive on November 23 1948

Immediate cause of death

Chronic Myocarditis

DURATION

6 yrs

Due to Intermittent hepatitis  
 Due to

6 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James H. Johnson M.D.  
 M. D. or other

Address Elkton, Md Date signed 12/1/48



CERTIFICATE OF DEATH

A FORM FOR THE REGISTRATION OF DEATHS

REGISTRATION OF DEATHS

RECEIVED

DEC 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11354

Reg. Dist. No. 94

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Lifetime  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County..... Cecil  
 City or town..... North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Helen R. Letts

## 3. (b) Social Security Number

none

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... William N Letts  
 6.(c) If alive, give age..... 50 years  
 7. Birth date of deceased (mo., day, yr.)..... Sept 17 1899  
 8. AGE: Years..... 49 Months..... 1 Days..... 18 If less than one day..... hrs. .... min.  
 9. Birthplace..... North East Cecil Md  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business.....  
 12. Name..... W. H. Diamond  
 13. Birthplace..... Ella Md Lilley  
 14. Maiden name.....  
 15. Birthplace..... md

16. Informant..... Wm N Letts  
 Address..... North East, Md  
 17. Burial Date thereof..... Nov 7, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... North East Methodist  
 Location..... North East Md  
 18. Funeral director..... Joseph R. Evans  
 Address..... North East Md  
 19. Nov 6 1948 Sarah E. Rothwell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 4 1948 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 10 1948 to November 4 1948  
 and that I last saw him alive on November 3 1948

Immediate cause of death

Acute myocardial infarction  
 Due to..... Nephritis, chronic, interstitial  
 Due to..... Diabetes

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... James L. Johnson M.D. or otherAddress..... E. Clinton, Md Date signed..... 11/8/48

RECEIVED

NOV 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

11355

94

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Lifetime  
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... North East Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William M Logan

## 3. (b) Social Security Number

none

4. Sex.....

m

5. Color or race.....

W

6.(a) Single, married, widowed, or divorced

Single

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

1870

6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

78

9. Birthplace.....

North East Rural, Md  
(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

12. Name.....

Benjamin F. Logan

13. Birthplace.....

Maryland

14. Maiden name.....

Harriet Burns

15. Birthplace.....

Maryland

16. Informant.....

John B Logan

Address.....

North East Md

17. Burial..... Date thereof.....

(Burial, cremation, or removal. Which?)

Nov 30 1948

(month) (day) (year)

Cemetery or crematory.....

Bay View Methodist

Location.....

Bay View Maryland

18. Funeral director.....

Joseph R. Lamm

Address.....

North East Md

19. Nov 30 1948.....

(Date rec'd by registrar)

Sarah E. Rothermel

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 27 Nov. 1948 at 9:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept1948, toNov1948

and that I last saw him alive on

27 Nov.1948

Immediate cause of death.....

① Uremia  
② Bl. Heart Failure

DURATION

Due to.....

① Benign Prostatic Hypertrophy

Due to.....

② A.S.C. V.D.

Other conditions.....

Ch. Cystitis & Pyelitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

W. H. Sadpowsky MD

M. D. or other

Address.....

Perryville, Md

Date signed.....

27 Nov 48

RECEIVED

DEC 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

11356

95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Rising Sun, Rural.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Cecil  
 City or town Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2(a) If veteran, name war .....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife .....

6. (c) If alive, give age .....

7. Birth date of deceased (mo., day, yr.) Aug. 12. 1946

8. AGE: Years 2 Months 2 Days 23 If less than one day  
 .hrs. .... min.

9. Birthplace Ellettsville Md.  
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

12. Name Frances MacCauley13. Birthplace Rowlandville, Md.14. Maiden name Eva McGlothlin15. Birthplace Grundy Va.16. Informant Frances MacCauleyAddress Nottingham Pa. R. F. D.17. Burial Date thereof Nov. 10. 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West NottinghamLocation Near Coloma.18. Funeral director J. E. JasonAddress Rising Sun, Md.19. Nov 8-48 Registrar Wm. H. H. H. H.

(Date of death by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH December 6. 48. 1230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-3-48 to 11-6-48and that I last saw him alive on 11-6-48Immediate cause of death CoronaryDue to Intestinal rupture

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

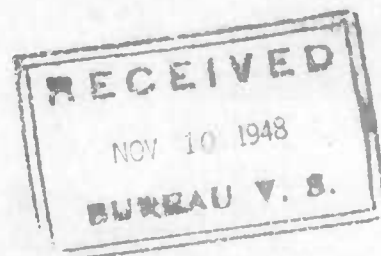
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE Wm. H. H. H.Address Rising Sun, Md.Date Signed 11-6-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age and birth date shown on:  
 FILM No. G 113 DEC -3 1948 MARYLAND STATE DEPARTMENT OF HEALTH  
 2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94

11357

1. PLACE OF DEATH:

County..... CECIL  
 City or town..... NORTH EAST  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
NORTH EAST - R.D. 1  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... M.D. County..... CECIL  
 City or town..... NORTH EAST  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R.D. 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JOSEPH B. MCKINNEY

3. (b) Social Security Number

4. Sex..... M. 5. Color or race..... WHITE 6. (a) Single, married, widowed, or divorced..... MARRIED  
 6. (b) Name of husband or wife..... BERTHA H.  
 6. (c) If alive, give age..... 77 years  
 7. Birth date of deceased (mo., day, yr.)..... JAN. 11, 1878  
 8. AGE: Years..... 70 Months..... 69 Days..... If less than one day..... hrs. .... min.

9. Birthplace..... MD.  
 (Town, county, and state)  
 10. Usual occupation..... GUARD  
 11. Industry or business..... GOVT.  
 12. Name..... AMOS MCKINNEY  
 13. Birthplace..... MD.  
 14. Maiden name..... GROVES  
 15. Birthplace..... MD.

16. Informant..... BERTHA H. MCKINNEY  
 Address..... NORTH EAST R.D. 1

17. BURIAL Date thereof..... NOV 23 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... BETHEL CEM. CHESAPEAKE  
 Location..... Chesapeake City - MD.

18. Funeral director..... Joseph R. Chant  
 Address..... North East, Maryland

19. NOV 20 1948 Sarah E. Rothermel  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 20 Nov 1948 at..... 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug 1948 to..... 20 Nov 1948  
 and that I last saw him alive on..... 19 Nov 1948

Immediate cause of death..... Bronchopneumonia  
 DURATION..... 7 days

Due to..... Cerebral Thrombosis - left 3 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Klaus H. Thueber M.D.  
 M. D. or other

Address..... North East Md Date signed..... 20 Nov 48

RECEIVED

NOV 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **96**

### 1. PLACE OF DEATH:

County **Cecil**  
City or town **Perry Point**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **3 1/2 hrs.**  
Hospital, institution, or street address where death occurred:  
**VA Hospital, Perry Point, Maryland**  
How long in hospital or institution? **Same**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **West Virginia** County **Nicholas**  
City or town **Richwood**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war **WW II**

### 3. (a) FULL NAME

**MOLLOHAN, Frank M.**

### 3. (b) Social Security Number

**Unknown**

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Divorced**  
6. (b) Name of husband or wife **Unknown**  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) **October 10, 1908**  
8. AGE: Years **40** Months **0** Days **25** If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH **November 5, 1948** at **12:35 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death **Poisoning, acute, liquid, probably an alkali**  
DURATION **Unknown**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results **As above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Unknown** Date of \_\_\_\_\_

Where did injury occur? **Unknown**  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Baltimore County**

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Medical Examiner **Cecil County**

23. SIGNATURE **R. C. DODSON, M.D.** M. D. or other \_\_\_\_\_

Address **Rising Sun, Maryland** Date signed **11-5-48**

9. Birthplace **West Virginia**  
(Town, county, and state)  
10. Usual occupation **Machinist**  
11. Industry or business \_\_\_\_\_  
12. Name **Gary E. Mollohan**  
13. Birthplace **Clay County, W.Va.**  
14. Maiden name **Lizzie Mollohan**  
15. Birthplace **Braxton Co., W.Va.**

16. Informant **Brother, John Mollohan**  
Address **2329 Ruth Ave., Edgemere, Md.**

17. **Removal** Date thereof **11-5-48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory **Richwood Cemetery**  
Location **Richwood, West Va.**

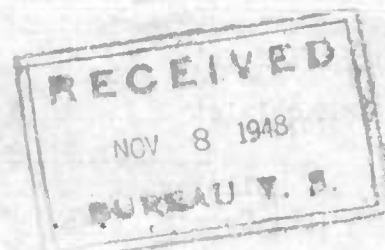
18. Funeral director **PENNINGTON & SON**  
Address **Havre de Grace, Maryland**

19. **Nov 5** 19 **48** **James S. Doughty**  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Unknown

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Richmond  
 City or town Richmond  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 314 Richmond Hotel  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I (Retired)

## 3. (a) FULL NAME

MYERS, Watson M.

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mrs. Leda Williams Myers  
 7. Birth date of deceased (mo., day, yr.) November 19, 1871 6.(c) If alive, give age years  
 8. AGE: Years 76 Months 11 Days 19 It less than one day hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Locomotive Manufacturer  
 11. Industry or business Williams Myers - deceased  
 12. Name Isle of Wight, County, Va.  
 13. Birthplace Pattie White - deceased  
 14. Maiden name Isle of Wight County, Va.  
 15. Birthplace

16. Informant Hospital Records  
 Address VAH, Perry Point, Md.

17. Removal Nov. 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hollywood Cemetery  
 Location Richmond, Virginia

18. Funeral director PENNINGTON & SON  
 Address Havre de Grace, Maryland

19. Nov 8 48 James S. Dwyer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1948 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 21, 1948, to November 8, 1948  
 and that I last saw him alive on November 8, 1948

Immediate cause of death Coronary sclerosis DURATION Unknown

Due to Arteriosclerosis, generalized Unknown

Due to Bronchopneumonia, bilateral

Other conditions (Include pregnancy within 8 months of death)

Major findings of operations ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE A.E. Trollinger M. D. or other

A.E. TROLLINGER, M.D., Chief, Professional Svcs.

Address VAH, Perry Point, Md. Date signed 11-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 10 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *91*

11360

### 1. PLACE OF DEATH:

County.....*Cecil*  
City or town.....*Chesapeake City*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....*Life*  
Hospital, institution, or street address where death occurred:  
*Chesapeake City, Md.*  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....*Md.* County.....*Cecil*  
City or town.....*Chesapeake City*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....*Md.*  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

*Wm Theodore Nowland*

### 3. (b) Social Security Number

4. Sex.....*M.* 5. Color or race.....*Wh.* 6.(a) Single, married, widowed, or divorced.....*Widowed*  
6.(b) Name of husband or wife.....*Martha F. Nowland*  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....*March 10 / 1870*  
8. AGE: Years.....*78* Months.....*8* Days.....*3* If less than one day..... hrs. .... min.

9. Birthplace.....*Chesapeake City, Md.*  
(Town, county, and state)  
10. Usual occupation.....*Retired*

11. Industry or business.....

12. Name.....*John Nowland*  
13. Birthplace.....*Chesapeake City, Md.*

14. Maiden name.....*Mc Inty*  
15. Birthplace.....

16. Informant.....*Edward J. Nowland*  
Address.....*Chesapeake City, Md.*

17. Burial.....*Burial* Date thereof.....*Nov 16 / 48*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....*Bethel*  
Location.....*Near Chesapeake City, Md.*

18. Funeral director.....*H.W. Phipps*  
Address.....*Elkton, Md.*

19. Date rec'd by registrar.....*Nov 16<sup>th</sup> 1948* Registrar.....*Anna B. [illegible]*

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Nov 13* 19*48* at.....*2:00 P*  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Jan* 19*48* to.....*Nov 13* 19*48*  
and that I last saw him alive on.....*Nov 13* 19*48*

Immediate cause of death.....*Pulmonary tuberculosis* DURATION.....*2 years*

Due to.....  
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

23. SIGNATURE.....*J. P. Davis MD* M. D. or other

Address.....*Chesapeake City, Md.* Date signed.....*11/15/48*

MARGIN RESERVED FOR BINDING

VS A16 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

NOV 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

20. DATE OF DEATH

1948, at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

For Cecil County

M. D. or other

Address

Date signed

6. (b) Name of husband or wife

8. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov 5

(Date rec'd by registrar)

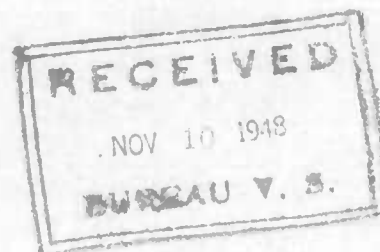
1948

Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

11362

## 1. PLACE OF DEATH:

County Cecil  
 City or town Colora Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 69 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Cecil  
 City or town Colora Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Harry Ramsay  
 7. Birth date of deceased (mo., day, yr.) Sept. 20. 1879 6. (c) If alive, give age 76 years  
 8. AGE: Years 69 Months 1 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Colora Cecil Co. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

MOTHER FATHER  
 12. Name Littleton Krause  
 13. Birthplace Md.  
 14. Maiden name Annie Lurey  
 15. Birthplace Penna.

16. Informant Harry Ramsay  
 Address Colora. Md. R. F. D.

17. Burial Date thereof Nov. 22. 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory West Nottingham  
 Location Colora

18. Funeral director J. E. Tyson  
 Address Rising Sun Md.

19. Not 20 48 Lincolnton  
 Date signed by registrar 11-20-48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 19 19 48 at 59 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 19 48 to Nov 19 19 48

and that I last saw her alive on Nov 18 19 48

Immediate cause of death Cerebral  
Arteriosclerosis

DURATION

48 hrs

Due to Arteriosclerosis

Due to Arteriosclerosis

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

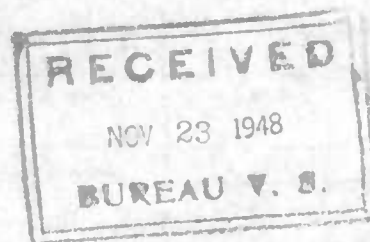
Injured at home, farm, industry, publc place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE H. S. ... M. D. or other

Address Darkington Md Date signed 11/20/48

1879  
69  
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Information

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov 11 1948

(Date rec'd by registrar)

J R Frazier Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 8, 1948, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

for Cecil County

M. D. or other

Date signed 11-9-48

RECEIVED

NOV 15 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Union Hospital - Elkton, MdHow long in hospital or institution? 7 days

## 3. (a) FULL NAME

Laura Seward

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife James Moore

7. Birth date of deceased (mo., day, yr.)

Unknown

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 86 Months 8 Days 9 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Caroline County - Md  
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

12. Name James ~~Edward~~ Buys13. Birthplace Centerville - Md14. Maiden name Eller McGinnis15. Birthplace Maryland16. Informant The deceased

Address

17. Burial Date thereof Nov 17/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory TownsendLocation Townsend, Del18. Funeral director H. W. LippertAddress Elkton, Md19. Nov 17 19. 48 H. W. Lippert  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton - MD  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1948 at 4:33a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 9 - 1948 to Nov 12 1948and that I last saw him or alive on Nov 11 1948

Immediate cause of death

Cardio Vascular disease

DURATION

unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

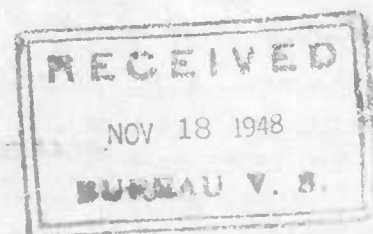
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. McGinnisAddress Elkton - MdDate signed 11/18/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Cecil  
City or town Elkton Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Union Hospital  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Cecil  
City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William Walters

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

8. (b) Name of husband or wife Margaret Walters

7. Birth date of deceased (mo., day, yr.) Aug 20 1862 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 86 Months 3 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chesapeake City, Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James Walteres

13. Birthplace no information

14. Maiden name Margaret Taylor

15. Birthplace no information

16. Informant William Walters Jr

Address Elkton Md R D

17. Burial Date thereof Nov 26 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Cherry Hill Md

18. Funeral director W. W. Pippin

Address Elkton Md

19. Nov 26 1948 Registrar J. B. Frazer  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 23 November 1948 at 8:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 November 1948 to 23 Nov 1948 and that I last saw him alive on 23 November 1948

Immediate cause of death Cardiac Failure DURATION \_\_\_\_\_

Due to Hypertension

Due to Atherosclerosis

Other conditions Semiplety

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George H. Kneis, Jr M, D, or other \_\_\_\_\_

Address Elkton, Md Date signed 11/23/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1948

BUREAU V. S.